A CLINICAL LECTURE ON SYPHILITIC DISEASES OF THE TONGUE.

Delivered at University College Hospital.

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GENTLEMEN,—We have had lately in the ward a remarkable case of gumma of the tongue, and I thought it would afford a good opportunity to say a few words to you concerning syphilitic diseases of the tongue, considering that cases of this description form a fair proportion of the affections you will have to treat in your practices.

PRIMARY SYPHILIS OF THE TONGUE.

With regard to primary syphilitic disease or chancre of the tongue I have first to say that it is a very rare thing. Personally I do not remember to have seen an actual chancre of the tongue, but I can show you here, in a German book containing good illustrations, a picture of a tongue with a chancre upon it. A chancre of the tongue, like a chancre of the lip or chancre of the finger, does not present that remarkable hardness which a chancre on the genital organs does. It is very important to remember that, and when you see a patient with a sore upon the lip (and sores on the lip are more common than on the tongue), and notice that there is no induration of the sore, but that there has been very early and rapid enlargement of the lymphatic glands beneath the jaw, you may conclude, especially if the patient is a young person, that in all probability it is a chancre; the same thing applies to the tongue.

The way in which the tongue may be inoculated with the syphilitic virus may vary, and one can imagine abominable practices occurring in certain well-known cities, but I hope not in London, whereby actual inoculation of the tongue may take place. You must remember, however, that a person may get a chancre of the tongue or of the lip perfectly innocently, because there is no doubt, in the present day at any rate, that mucous tubercles in the mouth can produce a primary chancre in the mouth of another person. I wish to put this point strongly, because up to within recent times it has been denied, but no leading syphilographer nowadays questions that syphilis is communicable by mucous tubercles. Since then these mucous tubercles are common in secondary syphilis, considering the careless habits people have of using cups and spoons and pipes after one another, it is not wonderful that from time to time a primary chancre occurs in the tongue. Primary chancre of the tongue must of course be treated like chancre elsewhere, that is to say with mercury.

SECONDARY AFFECTIONS OF THE TONGUE.

Referring to the evidence of constitutional syphilis, we happen to have here to-day a patient, who, as you see, has a well-marked secondary eruption. The man has evidently got secondary syphilis, and now on putting out his tongue you notice that he has a fissured tongue, and I have no doubt that at some period the site of these fissures was marked by mucous tubercles. I say so because I find that on turning his lip out a little at the corner, it will be seen that the lip and the tongue have mutually inoculated one another. It is common to find further back in the cheek patches of mucous tubercles, which are distinctly inoculated from the tongue to the cheek. These mucous tubercles are just the same "mucous plaques" as we call them that you find so commonly about the female genitals. We do not so often see mucous tubercles about the male genital organs, because in the male the skin is kept dry; but in the female, where there is moisture and probably some vaginal discharge, we very commonly get on the moist skin about the vulva and the anus mucous tubercles, of which I can shew you a very good representation in this book.

Here in this man I now show you there is exactly the same condition of things about the mouth, that is to say, one moist surface with another moist surface constantly touching

it, in a patient under the influence of the syphilitic poison, resulting in the development of mucous tubercles.

These mucous tubercles may, moreover, occur in children as the result of congenital syphilis, in children who exhibit other evidence of congenital syphilis such as coppery patches about the buttocks and mucous tubercles about the anus. This is very important because a child with mucous tubercles about the mouth may so easily infect a woman whose nipple it sucks, though it cannot infect its own mother, the mother having already syphilis in her system; this is known as "Colles's law."

Another symptom of constitutional syphilis about the tongue and mouth is the development of inflammation superficial in its character. With it we get very commonly a shedding of the superficial layers of the mucous membrane of the tongue, including the filiform papillæ. I believe that condition is much more common than is supposed, but it is not often seen, for what we more commonly meet with is the condition seen when the patient comes complaining of a sore tongue, with a history of having put up with the soreness for some weeks. Here the appearance has become altered, and more commonly the bald patch is found which is so significant of secondary syphilis of the mucous membrane of the tongue and mouth. The patient may have gone through the first stage without its having been recognised, and as a result of that shedding of the epithelium there is a certain amount of cicatricial tissue causing smoothness of the surface of the tongue, recognised as the characteristic "bald patch."

SYPHILITIC ULCERATION OF THE TONGUE.

We may have another condition following that—namely, inflammation going on to ulceration, and that may show itself in various ways. It generally is a multiple ulceration, making grooves in the side of the tongue, not affecting very much the dorsum, but involving fairly deeply the sides and tip of the organ. I send round an illustration, and in Fig. 1 of this plate you will see fissuring of the tongue and some hypertrophy of its tissue. Here is a better illustration, which shows exceedingly well the appearance after the ulceration has healed, and we have there a certain amount of thickening; you will notice also the sulci or grooves which have been cut into the tongue by the process of ulceration. That process may of course extend a good deal into the tissue of the tongue, and you occasionally find, as is shown here, a true glossitis or inflammation of the tongue due to the syphilitic poison. In the case of the woman whose tongue I lately removed you may remember that I called attention more than once to the fact that behind the gumma there was an ulcerated surface due to syphilis, so that we had there the late secondary and the tertiary manifestations of the disease together. You may even have the tongue split down the middle by ulceration; it is rare, but it does occur now and again.

We have, then, this ulceration, and we may have either with or after the ulceration a very considerable amount of chronic thickening of the tongue—a thickening of perhaps only one side of the tongue, and of a very chronic character. This thickening of the tongue is apt to alarm a patient, who immediately begins to think that he is suffering from malignant disease. I have no plate here which shows it, but you can understand that where there is chronic inflammation there may be chronic thickening, and that one side of the tongue may feel hard and lose a good deal of its ordinary characteristics.

The treatment for all forms of secondary syphilis of the tongue I am quite sure is the same, and that treatment is the administration of mercury. There is no use whatsoever in attempting to treat secondary syphilis of the tongue with potassium iodide; you must give the patient mercury, and you must push the mercury not merely constitutionally, but locally, if you wish to make a complete cure. I am in the habit of using a mercurial mouth-wash, beginning with a strength of gr. $\frac{1}{4}$ of perchloride of mercury to the ounce, that is to say, about 1 in 2,000, and this strength I gradually increase. My usual prescription is perchloride of mercury, gr. $\frac{1}{4}$, with 2 drachms of honey made up to an ounce of water. I tell the patient to take a mouthful of this, and to have his watch out and see that he holds the wash in his mouth for five minutes by the watch, as five minutes is a longer time than people think. It is quite useless to merely

tell a patient to use a mouth-wash; then he simply gargles a little and spits the lotion out, and that is of no use at all. The tongue must be "pickled," and if the patient takes his watch out and breathes through his nose, and holds the lotion in his mouth for five minutes two or three times a day, it is astonishing how these tongues improve. Mercury must be given to the patient at the same time internally, and there are many ways of giving it. I have myself come to the conclusion that there is no more satisfactory way of giving mercury than by inunction, that is to say, by rubbing it in over night when the patient is going to bed. The patient should rub the mercury into the inner part of the thighs or the front of the belly, beginning with half a drachm of the blue ointment and going on to a drachm. This rubbing may be continued for many nights together without producing irritation, but if that occurs then the site of the rubbing should be shifted to the lower part of the abdomen. One great advantage of prescribing mercury in this manner is that it gets into the system very gradually, and that the patient is not affected in the mouth. The patient bears the drug better, and it is a more satisfactory plan than giving mercury by the mouth. You must warn the patient that, though he may have a daily warm bath to cleanse himself, he should not use soap except once a week, when the ointment may be washed away. I generally recommend a man to wear pyjamas, and to wear the same pyjamas every night for a fortnight or three weeks, in that way securing the entrance of mercury into the system without any inconvenience.

Most of you have heard that at Aix la Chapelle there is a system of treating syphilis which is certainly extremely valuable. That system is nothing more nor less than what I have been describing to you. The people at Aix la Chapelle make a great fuss about the value of the sulphur water and the sulphur baths in use there; these are certainly very pleasant, but they have no real bearing on the cure; it is the steady daily rubbing in of the mercury by the attendants which produces such marked effects. The course at Aix la Chapelle is for six weeks, and it is easy to get a patient here in his own house to rub for six weeks, and then perhaps he may leave it off for a month or so, and then resume for a time. With reasonable precautions against getting wet and taking cold, I have found no difficulty in this treatment being carried out.

It is very important that you should never salivate a patient, that is a thing of the past; to avoid salivation it is the custom at Aix la Chapelle to use an alum mouth-wash. Every patient there carries about with him this mouth-wash, and he is continually rinsing out his mouth. I have no doubt that if a patient be treated in this systematic manner the most marked curative effects can be secured.

LATE SECONDARY OR EARLY TERTIARY?

Now let me draw your attention to the fact that there are cases of syphilitic tongue on the borderland between the secondary and tertiary stages; I mean cases which are not actually gummatous, but which are instances of late ulceration, and these cases are satisfactorily treated in the way I have indicated. I have a drawing here made as long ago as 1870 of the tongue of a man who was brought to me because it was thought that he had epithelioma. I did not think it was epithelioma, and on looking over his body found on his thigh a well-marked eruption which no one could possibly take for anything but syphilis. Under the influence of mercury that man's tongue got perfectly well, and I may add that there is no doubt that tongues have been removed before now for conditions which might have been cured by mercurial treatment. When I hear of a patient remaining well for years after removal of the tongue for epithelioma, I have my doubts as to the correctness of the diagnosis, and it is natural to do so in the case of patients surviving for many years such a deadly disease as epithelioma of the tongue.

TERTIARY SYPHILIS OF THE TONGUE.

We will now consider tertiary syphilis of the tongue, of which we have such a remarkable example in the case of the woman who came into the hospital early in October. She is a middle-aged woman who had got what no one could doubt was a well-marked ulcerated gumma of the tongue. She happened to come in at the time of the October examinations at the

colleges, and I sent her down as one of the cases. I believe there was only one opinion expressed, and that was that it was a case of well-marked gumma of the tongue. This gumma, you will remember, was in the ulcerated condition, and you must bear in mind that before it was ulcerated there was a hard mass to be noticed involving nearly the whole of the right side of the tongue, but in her case there was something more, for all through the tongue there were little nodules of syphilitic deposit. It was one of those cases of multiple gummata which are not commonly seen, the gummata spreading through the substance of the tongue. I ought to add that she had an enlarged gland under the chin. I thought myself that the state of irritation of her mouth was sufficient to account for that enlargement, and I did not at first consider that there was anything of a malignant character about the condition. I said at the time, incorrectly however, as it turned out afterwards, that we should cure the case by full doses of potassium iodide and a mercurial mouth-wash. We began with moderate doses of potassium iodide, giving it combined with ammonia and bark. She was put upon 10 grain doses, and seemed to be improving, and then we increased the dose to 20 and finally to 30 gr., but we noticed that she did not further improve. In consequence of a tendency to salivation I was obliged to stop the mercurial mouth-wash, and give her a lotion containing myrrh. What I generally order is just sufficient tincture of myrrh poured into warm water to make it milky. After some little time I felt quite sure that if there was not an epitheliomatous condition present that there ought to be, because the patient did not improve. It was clear that it would be better for her to get rid of the tongue than to allow the organ to continue in that condition, and the patient herself was only too glad to consent. A fortnight ago, therefore, I took away the whole tongue, and you may remember that I had to put my clamp-forceps behind the circumvallate papillæ just in front of the epiglottis. On taking away this large tongue it showed to the naked eye the pasty appearance in the red muscle which is so characteristic of gumma, and there were also present the small gummata scattered through the tongue which I have mentioned. I particularly said to Mr. Curtis, the surgical registrar, that I hoped he would make a careful examination because I was not at all satisfied that it was solely a gummatous condition, and eventually, quite at the back of the tongue, Mr. Curtis found a very distinct mass of epithelioma, a small amount certainly, but distinctly epitheliomatous. A specimen has been placed under the microscope for you to see to-day, and you can recognise there what no one can doubt to be epithelioma.

It is clear, then, that this patient, having gone through a prolonged course of ulceration of the tongue, eventually developed epithelioma, and I am glad therefore that I have removed the entire tongue. I hope I have removed the whole of the disease, but though I went close to the epiglottis, I am afraid she will have further trouble in connection with the glands in the chin. You will remember that last Wednesday I very carefully scraped them out, and cleaned up the part generally; and we must hope for the best.

In connection with these cases of gumma of the tongue which go on for a long time, and develop epithelioma, I will quote to you a saying of Mr. Jonathan Hutchinson: "If you irritate a part sufficiently long you may grow epithelioma." As an example of this take the irritation of a pipe continually affecting a lip, and ending in the development of epithelioma of the part, and this is a well-known fact clinically, for we hardly ever meet with epithelioma of the lip except in males who smoke. Given, therefore, any prolonged irritation, you have the probability that epithelioma will grow, and that is exactly what has happened in the case of this woman. It is this sort of case which is brought to you with a history that the patient has had a sore tongue, and has been under judicious medical care, with the result that, though the tongue has improved up to a certain point under potassium iodide, yet it has never got well. These cases of a double kind, if one may so call them, which have epithelioma grafted on to a gumma, may, and do, for a short time improve under the influence of potassium iodide, for no doubt the ordinary small-celled inflammatory exudation becomes absorbed, and things become improved for a time; but potassium iodide has no effect whatsoever on epithelioma, and the tumour goes on growing, eventually

resulting in some operation having to be done if the patient's life is to be prolonged.

The treatment of a gummatous condition I have already indicated, full doses of potassium iodide with the addition, as a rule, of a mercurial mouth wash. It is astonishing what a quantity of potassium iodide some of these patients will bear, taking sometimes 30 to 40 grs. three times a day, with the result that eventually a thorough healing may occur.

LEUKOPLAKIA.

There is one other thing I should like to say a few words about, and that is a disease of the tongue with which you are all familiar, which we call leukoplakia, and I put it last because it is by no means always of syphilitic origin. Leukoplakia may occur entirely apart from syphilis, the common cause being tobacco, but if a patient is not only the subject of syphilis but also smokes tobacco, he is very likely to have a much worse tongue than if he were free from syphilis. Although I do not say that every case of leukoplakia is complicated with syphilis, as of course that would be incorrect, still I do say that many cases arise in conjunction with syphilis, the result partly of syphilis and partly of local irritation, and further, I believe that you must always have that local irritation present in order to produce leukoplakia.

WARTS.

In connection with the subject of my lecture, there is another thing I must mention, and that is the condition known as warts. I show you here a man with tertiary syphilis of the palate and throat, and the point I want you to note is that at the base of the tongue, quite at the back of the organ, there is a somewhat warty condition. That is not a very common thing, but the condition is one of the evidences of syphilis, and this case affords a good example of it. He is being treated for tertiary syphilis, and you will notice that his face is scarred and that his palate is perforated. I am treating the warty portion of the tongue with nitrate of silver, and if necessary I shall try chromic acid, 10 grs. to the ounce. Another useful application is cyanide of mercury, 15 grs. to the ounce, brushed over the affected portion of the tongue. This often does wonders for this sort of thickening, and also for old chronic ulceration. It is necessary, of course, to be careful that the patient does not swallow any of the application.

I need hardly remind you that you must not confuse the syphilitic warts at the back of the tongue with the condition that sometimes is seen on a perfectly healthy tongue; I refer to the slight hypertrophy that may occur sometimes of one of the papillæ of the tongue. I lately saw a case of wart of this kind in a gentleman who had not the slightest trace of syphilis about him, it was merely a slight hypertrophy of one of the papillæ of the tongue, and the best treatment is to touch it with the acid nitrate of mercury.

ABSTRACT OF A CLINICAL LECTURE ON RECURRENT APPENDICITIS.

WITH REMARKS ON A SERIES OF FIFTY CASES TREATED BY
OPERATION.

Delivered at the Manchester Royal Infirmary.

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THE causation and symptoms of recurrent appendicitis, and its treatment by removal of the appendix, having been described, the following reference was made to a series of 50 operations which had recently been completed for this affection, as the conditions met with in the cases so treated served to illustrate many of the points to which attention had been directed.

CONDITION OF APPENDIX.

In almost every case the walls of the appendix were thickened, and at some point in its course the lumen was either partially or completely occluded. On the distal side of the obstruction the tube was frequently found to be dilated and distended with fluid, which in most cases was of a mucopurulent nature, but in a few instances clear and watery or consisting of pure pus. In some cases the appendix was quite

straight, in others twisted or sharply bent on itself, occasionally at such an acute angle that its tip was almost in contact with its cæcal extremity.

OCCURRENCE OF SUPPURATION.

In 15 cases suppuration had occurred in the neighbourhood of the appendix. In 12 instances a localised abscess was present, often of small size—for example, not containing more than half a teaspoonful of pus. In other cases there was no distinct collection of pus, but small caseous deposits, evidently the inspissated remains of former abscesses, of which the fluid portion had become absorbed. In 3 instances the suppuration was diffuse, there being well-marked evidences of general purulent peritonitis when the patients came under observation.

This fact—namely, the frequent occurrence of suppuration in recurrent appendicitis—should be borne in mind in the treatment of this affection, for it is a strong argument in favour of operative interference. Though in the majority of cases the attacks subside time after time without any formation of pus, yet there is always a great risk of this complication occurring, and it would appear that a repetition of the attacks is no safeguard against it. In most of the cases where an abscess had formed the attacks had been frequent, and in each of the 3 patients where the suppuration was diffuse, they had been so numerous that the patients had lost count of them.

The formation of pus was usually found to be associated with a perforation of the appendix, and was therefore probably excited by an escape of its contents. In one case the abscess presented in a very unusual situation—namely, on the anterior wall of the rectum—the first symptom indicating its existence being a sudden attack of retention of urine. The abscess was tapped and drained *per rectum* with a satisfactory result, and the patient, a male, made a good recovery.

FÆCAL CONCRETIONS.

In 7 cases fæcal concretions were found to be present; in 5 the concretion was lying inside the appendix, in 2 it was outside, having perforated the walls of the process and excited suppuration round it.

FOREIGN BODY.

In only 1 instance was a true foreign body present, and this was a pin, which was found in an abscess cavity in close proximity to the appendix. The pin had probably been lodged in the appendix for some time, and then ulcerated through its walls, for the process was surrounded by adhesions and almost obliterated. The head of the pin was encrusted with a considerable deposit of calcareous matter.

ADHESIONS.

In the majority of cases adhesions were present, in some instances so slight as to cause no trouble, in others so extensive and so dense that considerable difficulty was experienced, first in recognising, and afterwards in liberating and removing the appendix. Their presence or absence bore no relation to the number or severity of the attacks, and it was impossible to say before the operation whether or not they would be encountered. For example, there was not a trace of an adhesion met with in one patient who had suffered from about twenty well-marked attacks, while in others, after only two or three slight attacks, they were found to be so extensive as to render the operation extremely difficult. It was noticed that when a local thickening or induration could be felt during the quiescent period following an attack, adhesions were always present, but the absence of this sign could not be taken as an indication that they did not exist, for the appendix was often found lying behind the cæcum with its tip directed backwards, fixed and buried in a mass of adhesions, which it was impossible to recognise previous to operation, and not even after the abdomen was opened until the overlying cæcum had been drawn forwards and upwards out of the way.

A complication occasionally met with as the result of former attacks of appendicitis is intestinal obstruction from inclusion and compression of a coil of bowel in a mass of old adhesions. Several cases of this kind (not included in this series) have come under my observation where a median laparotomy was performed for the relief of the obstruction, and where the intestine was found so tightly constricted and bound down that its liberation was a matter of considerable difficulty.